PHP

QUALITY

ASSURANCE

MANUAL

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PREFACE

In the past, Alabama Medicaid's Inpatient Utilization Review (IUR) Program conducted reviews for medical necessity determinations for inpatient hospital stays. This was accomplished through performing utilization reviews for non-delegated and delegated hospitals. As needs were identified, focused reviews were added to the review process. The following summaries illustrate the IUR review process.

NON-DELEGATED HOSPITALS

A non-delegated hospital may be defined as a hospital that does not perform utilization review determinations for inpatient Medicaid recipients. In the past, IUR determined medical necessity for 100 percent of Medicaid admissions and continued stays through telephonic reviews. A date specific Prior Authorization (PA) number was assigned. IUR performed reviews for each recipient every 24-72 hours. When a review coordinator assessed that a recipient failed to meet criteria, referral was made to medical consultant(s). An unfavorable medical determination was then communicated to the facility by telephone and then written notice was mailed within 48 hours. When a continued stay determination was made, a new review date was assigned. Procedures were in place for Medicaid pending and retro-active reviews. The reviews required dedicated 800 phone lines and personnel.

DELEGATED HOSPITALS

A delegated hospital may be defined as a hospital that performs medical determinations for their current Medicaid inpatient population in accordance with the Code of Federal Regulations. IUR performed retrospective reviews on Medicaid hospital admissions by requiring hospitals to submit a monthly census. IUR selected a 25 percent sample based on diagnoses, medical necessity, and length of stay. Medical records were reviewed and compared to the established criteria. If criteria were met, the review was closed. If criteria were not met, the record was referred to two physicican consultants who determined medical necessity. Recoupments of amounts paid were initiated based on their recommendations.

In addition to a 25 percent review, Utilization Plans and Medical Care Evaluation Studies were requested annually and reviewed by IUR Coordinators. Compliance or correction letters with applicable follow-up were sent following the review.

UNDER 21 PSYCHIATRIC HOSPITALS

A 100 percent review of hospital admissions is performed for these specialized hospitals for children and adolescents. Separate psychiatric criteria are applicable for admission and continued

stays in such facilities. Initially, a paper review of each admission and continued stay review was performed. Effective October 1, 1995, telephonic reviews began with two dedicated phone lines for current admissions and continued stay reviews. Currently, admissions and continued stay reviews are being performed by the Prior Authorization Program.

OVER 65 PSYCHIATRIC HOSPITAL

In addition to the Under 21 Psychiatric Hospitals, the Prior Authorization Program performs a 100 percent review of hospital admissions for Over 65 Psychiatric Hospitals. Separate psychiatric criteria are applicable for admissions and continued stays in this acute care setting.

FOCUSED REVIEWS

The need for focused reviews for monitoring areas of high utilization arose. One of the tools available to IUR was an easytrieve of data. Data can be read from claims information and any selection combination can be achieved through a request and creation of a report. Three such reports were created for the purpose of monitoring specialized selection criteria:

Primary Diagnoses of Alcohol or Drug Abuse/Detoxification,
Utilization for Inpatients Aged 2-21, and
Surgery Date after Admission Date.

In March 1995, Alabama Medicaid adopted the “Alabama Medicaid Adult and Pediatric Inpatient Care Criteria." Provider Notice 95-6 notified the providers of this change. Criteria were developed by Medicaid to serve as guidelines for determining the need for inpatient hospitalizations, and are based on current Medicaid policies and procedures. This criterion is still in effect. Prior to this time, InterQual criteria had been utilized.

In an effort to perform more effectively and efficiently, Medicaid requested an assessment of the Utilization Management Program by an independent consultant group. Managed Care initiatives were introduced during the same time period and the need for change was identified. Planning and analysis of needs ensued. In October 1995, a new Hospital Reimbursement Program was initiated which was based on hospital cost experience. It later became known as Partnership Hospital Program (PHP).

The IUR Program was involved in the reorganization at Medicaid and became part of the Utilization Control Division thus acquiring a new name, Quality Assurance (QA) Program. A movement toward a change in focus was initiated. A Provider Notice (96-6) was mailed to all non-delegated hospitals advising of the need to change their status to a delegated status, thus, eliminating the need for hospitals to call in for utilization review determinations. Review Coordinators were assigned to all non-delegated

hospitals in order to reach a goal of 100 percent delegated by October 1, 1996. To date, all non-delegated hospitals have responded and have met the qualifications for delegated status.

INTRODUCTION

Effective October 1, 1996, hospitals entered into a Partnership Hospital Program (PHP) agreement with the Alabama Medicaid Agency. The objective of the Partnership Hospital Program is to provide inpatient hospital services to eligible Medicaid beneficiaries through arrangements that assure access to delivery of inpatient care, promote continuous quality improvement, include utilization review, manage overall inpatient hospital care, and cost efficiency. Through contractual agreement, the PHP shall maintain an Internal Quality Assurance System in accordance with 42 CFR 434.34 and 438.240 and must assure a Utilization Management Program is in effect and in accordance with 42 CFR 456.100-145, Subpart C.

The Alabama Hospital Association (AlaHA) contracts with the Alabama Quality Assurance Foundation (AQAF) to provide oversight of the PHPs' QI/UR activities. Per contractual agreement, AQAF will perform the following tasks:

UR/QA Committee, Composition, & Functions
Claims Data Analysis
Annual Claims Data Analysis Report
Retrospective Random Chart Review
Grievance Reports
Focused Studies
Improvement Projects
Clinical/Claims Data Feedback to PHPs/AlaHA/Medicaid
Assist with onsite Medicaid Reviews/Audits

The QA Program has been delegated the responsibility for monitoring the PHP's Internal Quality Management System. The PHP has 8 Districts within the State. Each District appoints and maintains a Quality Assurance Committee to fulfill PHP requirements. The Quality Assurance Committee is also responsible for the handling of grievances, appropriate corrective action, follow-through, and referral within a specified time frame as indicated.

This manual will more fully describe the Quality Assurance Program's responsibilities in the upcoming sections. Please refer to the Table of Contents for specific areas.

MISSION

QA's mission is to achieve an improved system for determining awareness of health care outcomes through the design and implementation of a new paradigm of Utilization Management. The purpose of the monitoring process is to systematically collect data to provide a basis for the development of reliable information from which to evaluate performance measures. This process will facilitate and promote performance awareness, performance measurement, and performance improvement.

GOALS & OBJECTIVES

Perform retrospective inpatient reviews
Promote early performance awareness
Enhance measurement reliability
Assess health care outcomes
Communicate awareness and outcomes
Facilitate managed performance
Encourage quality measurement
Monitor Quality Initiatives
Foster Quality Improvements
Evaluate Quality Assurance activities
Build ongoing knowledge base

QUALITY ASSURANCE WORK PLAN

The Quality Assurance Program will perform semi-annual and annual medical reviews to assure Internal Quality Assurance Program activities meet standards and are in compliance with Federal and State regulations and contractual agreements.

THE MONITORING PROCESS

Monitoring is an essential process for utilization management while determining unique performance awareness, utilization, patterns, and oversight.

The Quality Assurance monitoring and review process is an ongoing assessment that will strive to promote continual quality initiatives and improvements. Initial review areas may be revised and/or updated as necessary to reflect quality concerns in our changing health care environment.

THE REVIEW PROCESS

The PHP must maintain an effective utilization management program which identifies instances of inappropriate utilization (over and under), identifies aberrant provider practice patterns, ensures active participation of a formal review committee, evaluates efficiency and appropriateness of services delivery, facilitates program management and long-term quality, evaluates quality of care, and promotes continuous quality initiatives and improvements.

As previously mentioned, the Alabama Hospital Association (AlaHA) contracts with the Alabama Quality Assurance Foundation (AQAF) to perform the quality assurance functions for all PHP districts. In order to insure that each PHP contractor furnishes quality and accessible health care to enrolled recipients, the Quality Assurance Program (QAP) conducts semi-annual audits to determine that there is an effective internal quality assurance system in place. These audits are usually conducted in June and December and may be performed onsite or documentation may be sent to the QAP. Administrative requirements are requested from the AlaHA and quality assurance/utilization review requirements are verified onsite at the AQAF.

Based on paid claims, AQAF pulls a 5% random sample from each PHP district. The hospitals are then notified to send a copy of the medical record to AQAF for review. This master list is then submitted to the QAP in order to select a 25% random sample medical review from each PHP district. AQAF is notified by the QAP the selected records to have available for review. In addition to the above sample, 100% of records referred to physician advisors for utilization and/or quality concerns, will also be reviewed.

THE REPORTING PROCESS

Interpretation of Semi-annual review reports will be distributed to the Medicaid Medical Services Division and the AlaHA. Any compliance issues will be addressed with appropriate personnel at the Medicaid Agency before an exit conference is scheduled with the AlaHA.

PHP MANAGEMENT RESPONSIBILITIES

The purpose of Medicaid's review of quality management in the Partnership Hospital Program is to determine whether the contractors (the 8 prepaid health plans) have an effective quality assurance system in place. Reviewers are urged to consult HCFA's Quality Assurance Reform Initiative guidelines.

The PHP must maintain an effective utilization management program which: identifies aberrant provider practice patterns; ensures active participation of a formal review committee; evaluates efficiency and appropriateness of services delivery; facilitates program management and long-term quality; evaluates quality of care, and promotes continuous quality improvement and initiatives.

SEMI --ANNUAL REVIEWS

The QA Program will review the PHP on a semi-annual basis through an on-site visit or desk review for utilization and compliance purposes.

Perform semi-annual medical reviews as indicated

- Utilization Management Program
  - Utilization Reliability/Assurance Review
  - Utilization Review checklists and/or reports
  - Discharge Planning Activities
  - Coordination/Continuity of Care
- Quality Assurance System (PHP Internal)
  - QA Plan
  - QA Committee Meeting Minutes Qtr.1 and Qtr.2
  - Agreement(s) with external entities
  - Note Focused Studies established and in progress
- PHP policy review for Utilization Management
- Report observations and recommendations

ANNUAL MEDICAL REVIEWS

The purpose of Medicaid's review of quality management in the Partnership Hospital Program is to determine whether the contractors have an effective quality assurance system in place. The Code of Federal Regulations (434.53), requires that Medicaid Agencies "must establish a system of periodic audits to insure that each contractor furnishes quality and accessible health care to enrolled recipients. The system of periodic medical audits must (1) provide for audits conducted at least once a year for each contractor; (2) identify and collect management data for use by medical audit personnel; and (3) provide that the data include (i)reasons for enrollment and termination; and (ii) use of services." Federal

regulations (42 CFR 434.34 and 438.240) require that prepaid health plan contracts provide that the risk-based managed care plan has an internal quality assurance (QAP) that: is consistent with the Medicaid program's utilization review requirement; provides for review by appropriate health professionals of the process followed in delivering health services; provides for systematic data collection of performance and patient results; provides for the interpretation of this data to the practitioners; and, provides for making needed changes.

Perform annual medical reviews as indicated

Utilization Management Program

Utilization Reliability/Assurance Review

Utilization Plan Review Compliance

Utilization Review checklists and/or reports

Medical Care Evaluation Study Compliance

Discharge Planning Efforts

Coordination/Continuity of Care

Quality Assurance System (PHP Internal)

QA Plan next FY

QA Committee Meeting Minutes Qtr.3 and Qtr.4

Agreement(s) with external entities

Focused Study Review

Grievance System Review

Quality Initiatives Review

PHP policy review for Utilization Management

Report observations and recommendations

The Quality Assurance Program continues to monitor utilization management in accordance with Code of Federal Regulations 456.100-245.

FOCUSED STUDIES

Focused quality-of-care studies should be designed and implemented in accordance with principles of sound research design, implementation and appropriate statistical analysis. Results of these studies can be used to 1) compare the appropriateness and quality of care and services delivered with agreed-upon guidelines for the provision of that care, 2) identify areas requiring improvement, and 3) monitor improvement over time.

A Health Care Quality Improvement System for Medicaid Managed Care: A Guide for States (the HCQIS Guide) requires that focused studies have the following components:

A clearly defined study question that focuses on relevant areas of concern in health care.

Well-defined items (indicators) to be monitored and evaluated in order to answer the question.

A standard or standards against which the organization compares itself.

A method for analyzing results to indicate ways in which the organization can continuously improve the care it delivers to enrollees (HCQIS Guide 1993).

There must be four focused studies in process and/or completed every two years. Hospitals will be allowed to conduct two (2) Medicaid-specific studies and two (2) Medicare-approved studies during the two year period.

MEDICAL CARE EVALUATION (MCE) STUDIES

According to 42 CFR 456.141-145, each hospital must have at least one MCE study in progress at any time and must complete one such study each calendar year. The purpose of a MCE study is to 1) promote the most effective and efficient use of available facilities and services, 2) emphasize identification and analysis of patterns of care, and 3) suggest appropriate changes needed to maintain high quality patient care and efficient use of services. Annually, a 25% sample (maximum of 4) of participating PHP hospitals, per district, is selected and reviewed by the QAP.

UTILIZATION REVIEW (UR) PLANS

According to 42 CFR 456.100-141, each individual hospital, participating in the PHP, is required to maintain and follow an UR plan that reviews hospital admissions, continued stays, and has a description of methods used to select and conduct MCE studies. Annually, a 25% sample (maximum of 4) of participating PHP hospitals, per district, is selected and reviewed by the QAP.

QUALITY IMPROVEMENTS

The Quality Assurance Program will assure that each PHP has a System for Quality Assessment and Improvement that:

a) Demonstrates measurable improvement in priority clinical and inpatient services by using measurable indicators,

b) Employs a continuous quality improvement model following the cycle from identification of potential improvement through implementation of intervention and restudy/analysis to assure appropriate and timely change, such as remedial or corrective action, in clinical care and inpatient service delivery,

c) Addresses problematic patterns of health care in the aggregate and for individual providers,

d) Uses clinical care standards/practice guidelines.

Districts are responsible for assuring provisions for making needed changes and evaluating the response to interventions.

GRIEVANCES

According to 42 CFR 438.400, the Quality Assurance Program must assure the PHP has a system(s), for resolving members' complaints and formal grievances. This system includes:

a) Procedures for registering and responding to complaints and grievances in a timely fashion,

b) Documentation of the substance of complaints or grievances, and actions taken,

c) Procedures to ensure a resolution of the complaint or grievance,

d) Aggregation and an analysis of complaint and grievance data and use of the data for quality improvement, and

e) An appeal process for grievances.

Each subcontracting hospital is required to submit complaint/grievance logs to AQAF quarterly. AQAF compiles all information and submits a summary of logs to the QAP. The summary log is to be submitted within 45 days of the end of the quarter.

PRESERVING CONFIDENTIALITY

Pursuant to 42 CFR 434.6 (a) (8), the PHP, its providers, and Medicaid must provide safeguards of information concerning Medicaid eligibles as is required by 42 CFR 431, Subpart F and the Health Insurance Portability and Accountability Act (HIPAA).